STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 00 B. WING	08/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES HEALTH CARE CENTER	3301 N CALUMET AVE VALPARAISO, IN46383

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F0000	This visit was for the investigation of Complaint IN00094551. Complaint IN00094551- Substantiated, Federal/State deficiencies related to the allegations are cited at F-282 and F-323. Unrelated deficiency cited. Survey Date: August 16, 2011 Facility number: 000176 Provider number: 155277 AIM number: 100288940 Survey Team: Toni Krakowski, RN TC Vicki Manual, RN Census bed type: SNF: 4 SNF/NF: 99 NCC: 2 Total: 105 Census payor type: Medicare: 12 Medicaid: 66 Other: 27 Total: 105 Sample: 4	F0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Whispering Pines desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on September 9th, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies are cited in accordance with 410 IAC 16.2. Quality review 8/19/11 by Suzanne Williams, RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the physician of blood pressure	F0157	F157 It is the policy of this facility to develop, implement and enforce written policies and procedures to ensure a resident's	09/09/2011

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	values (Resident # C) and blood sugar values (Resident # E) that fell within call parameters for 2 of 4 residents reviewed for physician notification in a sample of 4. Findings include: 1. The clinical record of Resident # C, reviewed on 8/16/11 at 2:00 P.M., indicated diagnoses of, but not limited to: hypertension, dementia, and osteoporosis. A Physician Order, dated 8/8/10, indicated, "Lisinopril 5 mg (milligrams), Take 1 tablet by mouth daily...Metoprol Tar Tab 25 mg, Take 1 tablet by mouth daily. Hold if BP (blood pressure) is < (less than) 100/60 and notify..." Review of Resident # C's "Vital Sign Flow Record", indicated, "...6/9/11...8 A.M....BP 90/54...6/11/11...3-11 (P.M.)...BP 95/52...6/22/11...8 A.M....BP 98/58...7/9/11...3-11 (P.M.)...BP 90/56..."		physician and legal representative are notified if there is a change in the resident's condition. **I. Specific Corrective Actions:** The nurses who did not follow policy and notify the physician of the residents' low blood pressure were re-educated regarding our physician notification policy. There was a new order regarding blood sugars dated 4/27/11 that stated to notify the physician if the blood sugar was greater than 350. Therefore, the nurses did follow notification guidelines in June and July regarding resident E's blood glucose readings. [See In-Service Notice and Physician Order dated 4/27/11] **II. Identification and correction of others:** All residents have the potential to have a change in condition that requires physician notification. All charts were reviewed for orders related to blood pressure and physician notification if indicated by results and physician order. **III. Systemic Changes:** All nurses attended a review of the Physician Notification Policy where the importance of following policy was stressed. [See In-Service Notice] **IV. Monitoring:** The Unit Managers will monitor existing and new orders related to blood pressures and audit charts as applicable for proper follow through on physician notification, if notification is required. This will be done daily for three months, then weekly for three months;	

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	The clinical record lacked documentation of physician notification of the above four blood pressure values. During interview with LPN # 2 on 8/16/11 at 3:00 P.M., she indicated Resident # C requires daily blood pressures for medication administration purposes and also has a full set of vitals including blood pressure taken weekly, typically on skin assessment days. She further indicated the call order would pertain to all blood pressures taken. 2. Resident #E's clinical record was reviewed on 8/16/11 at 12:25 P.M. and indicated diagnoses of, but not limited to, dementia, osteoarthritis, and diabetes mellitus. A Physician's Order, dated March 2011, indicated, "Notify MD of blood sugars < 60 or > 300." Review of the Glucometer Flow Sheets for the months of June and July, 2011, indicated blood glucose readings of over 300 in which the physician was not		then be discussed at QA for further monitoring or discontinuation. [See Blood Pressure Log and New Order MD Notification Audit tool]	

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	notified: 6/01/11 at 12:00 P.M. = 349, 6/01/11 at 5:00 P.M. = 350, 6/03/11 at 8:00 P.M. = 348, 6/04/11 at 12:00 P.M. = 334, 6/16/11 at 12:00 P.M. = 338, 6/17/11 at 12:00 P.M. = 317, 6/19/11 at 5:00 P.M. = 333, 6/22/11 at 12:00 P.M. = 327, 6/26/11 at 5:00 P.M. = 310 (A total of nine times for the month of June). 7/02/11 at 12:00 P.M. = 307, 7/16/11 at 12:00 P.M. = 342, 7/18/11 at 5:00 P.M. = 350, 7/21/11 at 5:00 P.M. = 323, 7/23/11 at 5:00 P.M. = 311 (A total of five times for the month of July). Nurse's Notes reviewed for the months of June and July of 2011 did not indicate the physician had been notified of the above elevated blood glucose readings. During an interview with LPN #3 on 8/16/11 at 2:50 P.M., she indicated nurses document in the Nurse's Notes when they notify a physician about a resident's issue. A facility policy titled "Physician Notification for Change in Condition Policy," dated 3/2010, indicated, "Policy: To assure the physician is notified of changes in the patient's condition as determined by the nursing assessment immediately upon observation...Notification of physicians and families/legal representatives will be documented in the resident's clinical			

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	record...." 3.1-5(a)(2)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow the Plan of Care for a resident with a history of falls, for 1 of 4 residents reviewed with care plans in a sample of 4. Resident: #E Findings include: Resident #E's clinical record was reviewed on 8/16/11 at 12:25 P.M. and indicated diagnoses of, but not limited to, dementia, history of falls, osteoarthritis, and diabetes mellitus. A "Fall Risk Assessment," dated 4/05/11 and updated 7/30/11, indicated Resident #E was a "High Risk" for falls. A Nurse's Note dated 7/30/11 at 7:30 P.M. indicated, "Called to rm (room) by CNA (certified nursing aide). Res. on floor in bathrm (sic) laying on L (left) side, blood on floor under head. Res. alert states 'My	F0282	F282 It is the policy of this facility to ensure services are provided by qualified persons in accordance with each resident's written plan of care. **Specific Corrective Actions:** The CNA who left resident E alone in the bathroom on 7/30/11 was re-educated regarding residents who are at high risk for falls and proper protocol. CNA #4 was re-educated regarding explicitly following the resident's care plan which stated "staff needs to stay with resident while toileting". [See August 1, 2011 summary, Progressive Discipline 7/30/11 and Orientation List Fall Prevention w/Renel 8/1/11 for Resident E's CNA on 7/30/11; for CNA #4 see Progressive Discipline 8/16/11 and August 29, 2011 summary] **II. Identification and correction of others:** All residents, with a history of falls, have the potential to be affected by failure to follow their plan of care. All residents at risk for falls had their CNA sheets updated to indicate their fall risk and the care plan intervention. **III. Systemic Changes:** All CNAs were	09/09/2011

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	nose is bleeding, help me up.' Blood from R (right) nare...laceration to (upper) of nose with bleeding, hematoma to R forehead with sm (small) amt (amount) bleeding...." A radiology report, dated 7/30/11, for Procedure: CT (computerized tomography) scan indicated, "There is a minimally depressed fracture through the nasal bridge...A large soft-tissue hematoma overlies the frontal bone and right periorbital (eye socket) region...." Resident #E's Care Plan, updated 7/30/11, indicated, "Problem: (Resident #E) is at risk for falls r/t (related to) history of falling, poor safety awareness and use of antidepressant medication...Approach: ...Staff needs to stay with resident while toileting. 8/01/11 assist x 1 and supervision." LPN #3 indicated in an interview on 8/16/11 at 3:10 P.M., Resident #E had been left alone in her bathroom on 7/30/11 while her CNA left the room to retrieve a clean gown for her. When she returned to the room, she found Resident #E lying on her bathroom floor and bleeding. During observation of Resident #E on 8/16/11 at 2:45 P.M., CNA #4 took her		in-serviced on the new CNA sheets and the new policy requiring them to carry the CNA sheets, related to the residents they are assigned to care for, with them while on duty. [See CNA Sheet Policy] **IV. <u>Monitoring:</u>** Compliance with the new policy will be monitored by the Unit Manager and/or designee. Daily on each shift it will be verified that each aide is carrying the CNA sheet for the residents assigned to them. After three months the checks will decrease to weekly checks. Monitoring will be reported monthly at the QA Meeting. After six months the Quality Assurance Committee will decide if monitoring may be decreased or discontinued. [See CNA Sheet Audit tool]	

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	into the bathroom and assisted her onto the toilet. CNA #4 then exited the resident's bathroom, closed the door, and waited for Resident #E to finish. During an interview with Resident #E's POA (Power of Attorney) on 8/16/11 at 4:00 P.M., she indicated she was told her mother would not be left alone in the bathroom without a staff person for supervision. A facility policy titled "Fall Prevention Program," dated April 2011, indicated, "Purpose: ...To identify residents risk factors and implement preventive measures when possible to prevent injuries...10. Care Plan currency: a. Identification of risk/issue...d. Initiation of preventive interventions...." This federal tag relates to complaint IN00094551. 3.1-35(g)(2)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide supervision for a resident with a history of falls which resulted in a	F0323	F323 It is the policy of this facility to ensure that resident environments are free of accident hazards, have adequate supervision, and proper assistive	09/09/2011

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	fractured nose, a laceration to the bridge of the nose requiring sutures, and several large facial contusions. This deficient practice affected 1 of 4 residents reviewed with falls in a sample of 4. Resident: #E Findings include: Resident #E's clinical record was reviewed on 8/16/11 at 12:25 P.M. and indicated diagnoses of, but not limited to, dementia, history of falls, osteoarthritis, and diabetes mellitus. A "Fall Risk Assessment," dated 4/05/11 and updated 7/30/11, indicated Resident #E was a "High Risk" for falls. Resident #E's most recent quarterly MDS (Minimum Data Set) Assessment, dated 6/28/11, indicated she was severely impaired cognitively and needed extensive assistance of one staff person for transferring from one surface to another. Review of Nurse's Notes, dated 6/29/11 at 1:30 P.M., indicated, "Res. (resident) found sitting on floor of bathroom. Res. states that she was 'just trying to use the toilet.' Assessment completed, no s/s (signs or symptoms) of injury noted...will		devices. **I. Specific Corrective Actions:** The CNA who left resident E alone in the bathroom on 7/30/11 was re-educated regarding residents who are at high risk for falls and proper protocol. [See attachments listed for F282] **II. Identification and correction of others:** All residents, with a history of falls, have the potential to be affected by failure to follow their plan of care. All residents at risk for falls had their CNA sheets updated to indicate their fall risk and the care plan intervention. **III. Systemic Changes:** All CNAs were in-serviced on the new CNA sheets and the new policy requiring them to carry the CNA sheets, related to the residents they are assigned to care for, with them while on duty. The Fall Prevention Policy was revised and all nursing staff were educated on the revised policy. [See CNA Sheet Policy, Fall Prevention Policy, and In-Service Notice] **IV. Monitoring:** Compliance with the new policy will be monitored by the Unit Manager and/or designee. Daily on each shift it will be verified that each aide is carrying the CNA sheet for the residents assigned to them. After three months the checks will decrease to weekly checks. Monitoring will be reported monthly at the QA Meeting. After six months the Quality Assurance Committee will decide if monitoring may be	

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	continue to monitor...." A Nurse's Note dated 7/30/11 at 7:30 P.M. indicated, "Called to rm (room) by CNA (certified nursing aide). Res. on floor in bathrm (sic) laying on L (left) side, blood on floor under head. Res. alert states 'My nose is bleeding, help me up.' Blood from R (right) nare...laceration to (upper) of nose with bleeding, hematoma to R forehead with sm (small) amt (amount) bleeding...7:50 P.M. Notified Dr. (Name) of status. Order rec (received) to send to ER (emergency room) for eval (evaluation)...8:45 P.M. ...Sm amt bleeding cont (continues) from R nare, sm. amt. bleeding from forehead and nose lac (laceration)...Res. now c/o (complains of neck pain)...9:30 P.M. Ambulance here to transfer to ER...7/31/11 at 4:05 A.M. returned to facility with POA (Power of Attorney) via ambulance...Bil. (bilateral) eyes with bruising" 3:00 P.M. Purple bruising to face remains. Sutures to bridge of nose...9:00 P.M. ...Edema (swelling) to nose. OU (both eyes) dark purple around...." A radiology report, dated 7/30/11, for Procedure: CT (computerized tomography) scan indicated, "There is a minimally depressed fracture through the nasal bridge...A large soft-tissue hematoma overlies the frontal bone and		decreased or discontinued. [See CNA Sheet Audit tool]	

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	right periorbital (eye socket) region...." LPN #3 indicated in an interview on 8/16/11 at 3:10 P.M., Resident #E had been left alone in her bathroom on 7/30/11 while her CNA left the room to retrieve a clean gown for her. When she returned to the room, she found Resident #E lying on her bathroom floor and bleeding. During observation of Resident #E on 8/16/11 at 2:45 P.M., CNA #4 took her into the bathroom and assisted her onto the toilet. CNA #4 then exited the resident's bathroom, closed the door, and waited for Resident #E to finish. Resident #E's Care Plan, dated 3/30/11 and updated 6/29/11, indicated, "Problem: (Resident #E) is at risk for falls r/t (related to) history of falling, poor safety awareness and use of antidepressant medication...Approach: ...Assist with tolieting (sic) q (every) 2 hrs (hours) per unit schedule and w/CNA (with certified nursing aide). Encourage res. (resident) to wait for assist." The Care Plan was again updated on 7/30/11 (after the 7/30/11 fall) and 8/01/11 with the following new approaches added: "Staff needs to stay with resident while toileting. 8/01/11 assist x 1 and supervision."			

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	During an interview with Resident #E's POA (Power of Attorney) on 8/16/11 at 4:00 P.M., she indicated she was told her mother would not be left alone in the bathroom without a staff person for supervision. A facility policy titled "Fall Prevention Program," dated April 2011, indicated, "Purpose: ...To identify residents risk factors and implement preventive measures when possible to prevent injuries. Purpose: It is the policy of Whispering Pines Health Care Center to establish processes and systems through a Fall Prevention Program to provide for the safety of all residents in the facility, when possible. The program will include measures which determine individual risk of each resident by assessing the risk of falls, and implementation of appropriate interventions to provide necessary supervision...Standard Fall/Safety Precautions for all Residents: ...11. Residents who require staff assistance will not be left alone after being assisted to bath, shower or toilet...." This federal tag relates to complaint IN00094551. 3.1-45(a)(2)			